Belfast Health and Social Care Trust
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TRUST BOARD

SUBMISSION TEMPLATE

MEETING	**Trust Board**	**Ref No. 5.4.b**
DIRECTOR	**Gillian Traub** **Interim Director**	**3 September 2021**
Muckamore Abbey Hospital - Update		
Purpose	This paper provides an update in respect of the Muckamore Abbey Hospital Leadership and Governance Review	
Corporate Objective	• Safety and Quality	
Key areas for consideration	Trust Board are asked to note the feedback received from staff members and former staff members who were interviewed by the Leadership and Governance Review Team when asked to provide comments on factual accuracy pertaining to the Review Report.	
Recommendations	• For Information	

Factual Accuracy Check

Muckamore Abbey Hospital Leadership and Governance Review

2012 - 2017

Background

The Leadership and Governance Review into Muckamore Abbey Hospital 2012 – 2017 was published on 5 August 2020. The Trust Board and Executive Team welcomed the publication of the Review and have demonstrated a commitment to ensuring that the learning and recommendations of the review are implemented. Updates in respect of the implementation of these recommendations have been previously provided to Trust Board and will continue to be updated.

Following publication of the review, Dr Jack established a Leadership and Governance Review Group which met for the first time on 19 August 2020. This Group comprises the Chairman, Executive Directors, Director of Human Resources and the Interim Director for Learning Disability Services.

Rationale and Methodology

The Group recognised the importance of identifying and responding to any factual inaccuracies continued with the report for the integrity of the review process. It was noted that the Trust had not been given the opportunity to complete a factual accuracy check prior to the report's publication, and that staff and former staff who the review team met with were not provided with a record of their interviews.

Consequently, the Interim Director for Learning Disability services was asked to undertake a factual accuracy check of the report. In October 2020, all members of staff and former members of staff who had been interviewed were contacted, asked to review the report and to highlight any purported statements of fact which they could demonstrate were inaccurate. Staff were also requested to provide evidence where available.

Factual Accuracy Report

Feedback was received by some staff and former staff, but not by all. Those who did provide feedback, either highlighted sections, which they identified as factually inaccurate, or provided a comment. Members of the Group felt it would be important to capture both types of feedback and this is contained in the attached table.

Trust Board

Members of Trust Board are asked to note the feedback received. It is proposed that this feedback will be retained, along with the papers from the Leadership and Governance Review Group, and provided to the Public Inquiry or in response to any inquiry associated with the Leadership and Governance Review process or report.

BHSCT FACTUAL ACCURACY RESPONSE
Leadership and Governance Review Report (2012 – 2017)

Muckamore Abbey Hospital

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
30	6.16 and 6.18	"The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board."	Assurance SAI arrangements did not report via or merge with the Governance Steering Group at any stage. Prior to the introduction of the Learning from Experience Steering Group in 2013, the Trust had an SAI Review Board in place which reported directly to the Assurance Group. This group was chaired by the Director of Nursing and membership was at Director level, with Co Director Risk & Governance, Nursing and User Experience and HR. Its main duties were : • Review all SAIs reported since the previous meeting, including the specific method of investigation; • Ensure that appropriate learning, recommendations and action plans from adverse incidents have been identified;	N/A	Assurance Framework and relevant Terms of Reference. These will be compiled as part of the preparation for the Public Inquiry

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
			• Ensure that learning, where appropriate is shared across the region and with other organisations; • Seek regular assurance that local learning is being implemented and adequate progress is being made against action plans; • Review status reports for external bodies for example HSCB/ RQIA /HSCNI as and when required; • Contribute to the quarterly and annual reporting arrangements to the Assurance Committee. A decision was taken in 2013 to establish a Learning from Experience Steering Group (LfE). Its main duties were • Reviewing and approving assurance updates from each of the sub committees on a quarterly basis • Receiving learning reports as escalated • Agreeing learning – the format, method and appropriate level of dissemination both internal and external to the organisation		

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
			• Seeking assurance that sharing of learning has occurred and that learning has been used to improve safety and quality. The LfE Steering Group had oversight for a number of sub committees including a re-constituted group now known as the SAI Review Group. Provided by C Cairns, email to G Traub of 22.12.20		
30	6.18	"The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. **6.15** may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them.	The reference at this point should in fact be to paragraph **6.16** (see above), rather than to **6.15.** Provided by Dr C Jack	N/A	N/A

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation."			
37	6.38	"The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the: - **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory	This section does not note the non-clinical support services operational remit of the Director of Nursing and User Experience. Provided by B Creaney, email to G Traub of 22.12.20		The extract provided by the Review Team is taken directly from the Assurance Framework document.

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;"			
39	6.42	"The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to	N/A	The role of the ADoN, part service manager (70%) and part nursing (30%) was originally a joint post with learning disability and mental health. In 2013 (approximately), the then Director of the service agreed to appoint a position for each service and the then Service Manager was appointed. Provided by B Creaney, email to G Traub of 22.12.20	N/A

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		their Directorate role and 30% to their professional role as Associate Directors of Nursing."			
39	6.43	"This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing."	N/A	The review of the role of the ADoN and the implementation of the Collective Leadership Strategy were separate. The review of the ADoN role was undertaken some two years in advance of the development of the Strategy. The EDoN recommended to the Executive Team the managerial and the professional roles should be separated to enable the Divisional Nurse to provide professional oversight in respect of workforce, education, regulation and safety and quality. Provided by B Creaney, email to G Traub 20.12.20	Relevant extract from minutes of Executive Team would be required to evidence this. These will need sourced as part of compilation of documents for the Public Inquiry
39-40	6.44	"The Executive Director of Nursing met formally on a	N/A	Monthly meetings were held with the senior	Minutes of the Senior Nursing and

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		monthly basis with Co Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely: - patient, quality and safety; - patient experience; and - professional nursing. Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing.		nursing and midwifery teams. On alternate months a workforce and a nursing governance including 'fitness to practice' meeting was held after the general monthly meeting, therefore effectively each meeting on alternate months. Provided by B Creaney, email to G Traub 20.12.20	Midwifery Team meetings, Bi-monthly Assurance Meeting Bi-monthly Workforce Meeting - structure algorithms and accountability reports as submitted to the Review Team
43-44 & 56-57	6.55 and 6.95	6.55 "The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH." 6.95 " Short term workforce planning resulted in the recruitment of staff on	The ADoN raised concerns about workforce and with the support of the EDoN secured additional funding for additional nursing support staff and an agreement to recruit for permanent positions to the workforce in 2012, following escalation of a red risk. The nurse staffing ratios for the period of the review were 158 wte registrants and 180 wte non-registrants. This was at times compounded by high levels of nursing sickness within the non-registrant workforce predominantly.	N/A	Minutes of the Senior Nursing and Midwifery Team meetings, the bi monthly Assurance Meeting and the bi monthly Workforce Meeting Relevant extract from minutes of Executive Team are required to evidence this. These will need sourced as part of

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		temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors."	The nurse ratio was 64:36 - 77.23. The highest ratio within PICU. Absence and vacancy rates were mitigated by the use of overtime, bank and agency staff and a number of substantive staff worked additional hours. Provided by B Creaney, email to G Traub 22.12.20		compilation of documents for the Public Inquiry.
57	6.96	"Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time.	The nurse ratio was 64:36 - 77:23. The highest ratio within PICU. However as sickness absence increased this was not always maintained and at times non registrant staff were utilised. The Service Manager was tasked to ensure a minimum of two registrants were available 24 hours per day, this was overseen by the Divisional Nurse and the Co Director for nursing workforce.	N/A	Confirmation of dates in respect of these comments will need to take place as part of the preparation for the Public Inquiry.

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		The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster."	Provided by B Creaney, email to G Traub of 22.12.20		
58	6.100	"An examination of correspondence between the Ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and the skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services Risk Register during the spring/summer 2012 as a high risk. Yet this risk was not placed on the Trust's Corporate Risk Register as per the Trust's policy.'	Nursing staff levels were a Trust wide staffing issue. Executive Team were aware of this and there was a Trust risk. MH/LD were included but the risk did not specify individual areas. Provided by C McNicholl, conversation with G Traub of 21.10.20	N/A	Corporate Risk Register
75	7.14	"Responsibility for MAH was included in the Directorate of SW, CCS and Adult and Primary Care Services….Director of Social	N/A	This is incorrect. At the time of the BHSCT forming the Director of Children's managed a	PowerPoint presentation which was completed in November 2007 showing structures.

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		care and a Director of Adult and Primary care."		range of Children's services and the RJM and RBHSC. There was a separate Director for Older People and a separate Director for LD and MH. When BM retired (some time around 2010/2011), MH and LD joined the Children's Directorate, it then became a wider directorate until the Director left in 2012. CCS then became a very small Directorate in 2012 and MH/LD joined Older Peoples under MH. This remained the position until the Director retired in 2016. Provided by C Diffin, email to K Alexander of 29.10.20	HR process will identify Trust structures and postholders as part of compilation of documents for the Public Inquiry.
76	7.15	"The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time	N/A	Bullet 6. Other Trusts had two or three persons in post discharging the functions required of the post holder.	The Position Paper referred to here will need to be sourced as part of compilation of

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		the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included: Bullet 6. Other Trusts had three persons in post discharging the functions required of the post holder."		Provided by C Worthington, email to G Traub of 09.11.20	documents for the Public Inquiry.
77	7.17	"The Review Team was told that the decision to surrender the Co-Director for Learning Disability and the Band 8B post for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any	This is inaccurate. For senior posts, there had to be a full business case written, approved by the Director of Finance and the Director of HR. They had a few queries and I made some changes – they signed it off and then it was signed by the then Chief Executive. It then had to go to DOH for approval.	N/A	Business Case – this has not been located to date.

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		discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made"	Provided by C McNicholl, conversation with G Traub of 21.10.20		
78	7.20	"Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or	At interview, EDoN advised the Review Team that she always found the staff welcoming and was aware of the challenging nature of the environment. EDoN has advised that she did not state she detected no issues of concern she has advised that she stated "I have asked myself what did I not see" as she had always found the patients well cared for and the staff receptive and keen to showcase their work and achievements in their practice development and education. Provided by B Creaney, email to G Traub of 22.12.20	N/A	This is a recollection. Unfortunately minutes of interviews were not kept or shared to enable confirmation of factual accuracy for EDoN or any other member of staff interviewed by the Leadership and Governance Review Team.

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		patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern."			
79	7.22	"Documentary evidence confirmed that efforts by the Service Manager to highlight the staffing difficulties through the hospital's risk register created tension between her and the Service Improvement and Governance manager who asked her to downgrade it from a serious to a moderate risk.'	N/A	The title Service Improvement and Governance Manager has been referred to in a number of paragraphs throughout the Report and it has been noted that the role has been held by more than one post holder. It is suggested that there is some further definition to a specific period of time e.g. "Service Improvement and Governance manager at [that] time" Provided by J Austin, email to G Traub of 21.10.20	HR process will identify Trust structures and postholders as part of compilation of documents for the Public Inquiry

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79	7.22	"The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was, in the view of the Review Team, a failure of the Service Improvement and Governance manager to escalate it appropriately."	The SAI notification was actually sent to the Co-Director, which is the correct BHSCT process, not the Governance Department. Provided by J Austin, email to G Traub of 21.10.20	N/A	Email of SAI notification being sent to Co-Director Provided by J Austin to G Traub on 21.10.20
79	7.22	"The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104)."	This comment is taken out of context. There was a lot of discussion at that time and the situation was unfolding rapidly. The first single incident was reported through Adult Safeguarding processes but as the situation escalated it was felt it was much better to report all incidents in one SAI as a level 3 to allow a thorough and independent review to take place. which did happen.	N/A	Email with evidence attached Provided by J Austin to G Traub on 21.10.20

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
			Provided by J Austin, email to G Traub of 21.10.20		
79	7.23	"At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates."	This should read "At the end of September 2017" the Director relinquished responsibility for the Adult Directorate" Provided by C Worthington, email to G Traub of 09.11.20	N/A	HR process will identify Trust structures and postholders as part of compilation of documents for the Public Inquiry
90	6th Bullet Point	From Table of Summary Comments and Findings ….. • "Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the 91 Corporate or Principle Risk Registers."	Nurse staffing issues were regularly escalated and discussed at Executive Team. The EDoN placed nurse staffing on the principal risk register in April 2014. Provided by B Creaney, email to G Traub of 22.12.20		Executive Team, Assurance Committee, Risk Register and Principal Risk Document Relevant extracts will need sourced as part of compilation of documents for the Public Inquiry.
116	8.62	"The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as	N/A	It would be important that clarity be provided in relation to which specific 'previous inquiries' this refers to. What other inquiries have there been	N/A

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions." "In the opinion of the Review Team the history of **previous**		as the Trust is unaware of these – and in addition the Ennis Ward investigation was an SAI, not an inquiry. Provided by Dr C Jack	

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		inquiries of MAH provided a context supportive of an early consideration of the potential for institutional abuse."			
138 and 139	8.125 and 8.126	8.125 "The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the A Way to Go report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his	N/A	The Complaints Department closed the complaint on 30th August 2017 as the matter was being addressed via Adult Safeguarding. The wording on the letter to Mr B, suggests any outstanding concerns can be addressed at the conclusion of the ASG process. However this wording is not clear and the provider of comment stated she worked with the senior manager for complaints to encourage her to change this letter so that it is very clear the complainant needs to write again if he remains unhappy with the conclusion of the ASG processes. Provider of evidence also stated she encouraged the complaints manager to ask Mr B to assist with this piece of work.	J Austin email to G Traub of 21.10.20

Page	Para	Text under consideration	Factual Accuracy	Other Comment or Clarification	Evidence
		complaint further from November 2018." 8.126 "As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017."		Provided by J Austin, email to G Traub of 21.10.20	
165	Point 6	"The size and scale of the Trust means that Directors have a significant degree of autonomy. The Trust should hold Directors to account."	It is inaccurate to suggest that Directors were not held to account. There was a system in place to hold Directors to account – for example, there were : • Monthly Directorate Performance Meetings • Annual Accountability Meetings • Monthly Chief Executive and Director meetings • Annual Appraisal/Objective Setting Provided by C McNicholl, conversation with G Traub of 21.10.20	N/A	Documentary evidence will be sourced from C McNicholl's files as part of compilation of documents for the Public Inquiry.